STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185399	A. BUILDING _____ B. WING _____	07/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND VILLA CARE AND REHABILITATION CENTER	8005 US HWY 60 WEST LEWISPORT, KY 42351

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard recertification survey was conducted 06/29/10 through 07/01/10. Deficiencies were cited, with the highest S/S being a "G".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Heartland Villa Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	07/22/10
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure that one resident (#5), in the selected sample of 12, who was fed and received medications through a gastrostomy tube (G-tube), received the appropriate treatment and services to prevent aspiration. Observation revealed one nurse failed to check placement of the G-tube, prior to administration of medication. Findings Include: A review of the facility's undated policy, "Enteral Nutrition" revealed for the continuously tube-fed resident, placement should be tested every four to twelve hours and before medication administration. An observation of a medication pass, on 06/29/10 at approximately 3:40 PM, revealed Licensed Practical Nurse (LPN) #4 administered	F 322	F322 The facility will continue to ensure that resident's who are fed by naso-gastric or gastrostomy tube receive the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. With respect to resident(s) affected by the alleged deficient practice: Resident #5 was assessed by the Director of Nursing Services (DNS) on 06/29/10. No negative outcomes were noted. The Treatment Administration Record (TAR) was updated to reflect assessing/evaluating placement of the gastrostomy tube prior to	07/22/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Paula D. Bandy | Administrator | 7-22-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 322	Continued From page 1 Ciprofloxacin (antibiotic) 500 milligrams, crushed and mixed in water, via G-tube for Resident #5. LPN #4 did not check placement of the G-tube, prior to the medication administration. An interview with LPN #4, on 06/29/10 at approximately 5:25 PM, revealed she did not routinely check G-tube placement with the administration of medications. G-tube placement was checked at the beginning of each shift. LPN #4 stated she should have checked placement, prior to the administration of the medication. Interview with the Director of Nursing, on 06/29/10 at approximately 5:30 PM, revealed G-tube placement should be checked, prior to the administration of any medication.	F 322	medication administration on 06/30/10. With respect to residents having the potential to be affected by the alleged deficient practice: 07/01/10, residents TAR's were reviewed and updated to reflect assessing/evaluating placement of the gastrostomy tube prior to medication administration. With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recur: LPN #4 was re-educated on 06/29/10 by the DNS to include administration of medication via gastrostomy tube. All nurse re-education was completed by the DNS on 06/29/10,	
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure one resident (#13), not in the selected sample, was free from significant medication errors. Resident #13 was admitted, on 06/10/10 at approximately 4:45 PM, with a physician's order for Hydrocodone/Lortab (narcotic) for pain every four hours. The facility failed to obtain the medication per their established policy and procedure for after hours delivery. The pain medication was not received or administered, until the next morning, on 06/11/10, at approximately 6:00 AM. Findings include:	F 333	on medication administration via gastrostomy tube. The Medication Administration Record (MAR) or TAR will reflect assessing/evaluating placement of the gastrostomy tube prior to medication administration. With respect to how the facility will monitor performance to ensure that solutions are sustained: Nursing management will audit MAR/TAR daily for three weeks to ensure documentation of assessment prior to medication administration is completed. Nursing Management will audit medication administration	07/03/10

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F 333	Continued From page 2 A review of the facility's "Pharmacy Products and Service Agreement", dated 09/13/07 and the facility's policy for "pharmacy telephone numbers/hours and order cut off times", dated 10/15/05, revealed an agreement for the pharmacy to provide "prompt and timely" deliveries to the facility. Deliveries would be made within one hour before and/or after the specified delivery time. In the event the pharmacy failed to make a delivery as required, the facility could obtain delivery of the medication from a third party pharmacy provider or request an emergency delivery of medication. The pharmacy hours of operation were identified as 8:00 AM until 5:30 PM, with a order cut off at 5:30 PM and 8:00 AM until 3:30 PM on Saturdays, with the cut-off time of 3:30 PM. After hours request for delivery was made through the answering service. In an emergency, the nursing staff checked the emergency kit and if the medication was not available, the nurse should communicate with the pharmacy and inform the pharmacy of a STAT situation and a special delivery would be made. A prescriber or nursing staff member could request a special delivery. Resident #13 was admitted to the facility on 06/10/10, from the hospital setting, with diagnoses which included Lupus (autoimmune disease), Neutrophilic Eccrine Hydradenitis (skin lesions), Chronic Low Back Pain, Compression Deformity of the Lumbar (L) 3 (low back), and Degenerative Joint Disease of the Spine at L4-L5 and L5-Sacrum (S) 1. Additional diagnoses included Suspect Complex Tear, Degenerative, of Posterior Horn of Medial Meniscus (knee), Hip Tendonitis and Osteoarthritis of Multiple Joints.	F 333	procedures per gastrostomy tube two times per week for three weeks to ensure compliance. The results will be submitted to the Performance Improvement Committee for review with recommendation and ongoing monitoring as indicated. Compliance date: 7/22/10 F333 The facility will continue to ensure that residents are free of any significant medication errors. With respect to resident(s) affected by the alleged deficient practice: Resident #13 was discharged home on 06/29/10. With respect to residents having the potential to be affected by the alleged deficient practice: 07/01/10, a MAR to Medication Cart audit was completed to ensure all medications were available in-house by the DNS and Administrator.	

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F 333	Continued From page 3 A review of the Admission Nursing Assessment, dated 06/10/10, revealed the resident expressed he/she was experiencing pain, had a pain history and currently received pain medication. A review of the Medication Administration Record (MAR), dated June 2010, revealed no medications, including pain medications, were administered to Resident #13, on 06/10/10. An interview with Resident #13, on 06/29/10 at approximately 11:15 AM, revealed he/she was admitted to the facility from the hospital, on 06/10/10 in the afternoon. The resident stated she was in "terrible pain" and the nurses (unidentified) told him/her the prescribed pain medication would arrive in the next pharmacy delivery, at 8:00 PM. However, the pain medication did not come and she did not receive the medication until the next day. Resident #13 described the pain experienced as "worse than excruciating" and "unbearable". Also, Resident #13 stated that when he/she asked for pain medication, he/she felt he/she "was a pain to them" (referred to staff). A (phone) interview with Resident #13, on 07/01/10 at 1:45 PM, (the resident was discharged on 06/29/10), revealed it was difficult to understand why it took so long to get pain medication, when the pharmacy was located only an hour from the facility. Resident #13 described the pain he/she experienced while without the medication as, "sitting in a bed of hot coals" and stated he/she,"didn't sleep all night, only dozed". The resident also expressed a concern for "other old people who might not be getting their medications". An interview with Licensed Practical Nurse (LPN) #3, on 07/01/10 at approximately 9:00 AM, revealed she admitted Resident #13, on 06/10/10.	F 333	With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recur: All Licensed Nurses have been re-educated on the facility guideline (Quick Reference Guide; QRG) for medication not available to include ordering of medications at time of admission and new orders, pharmacy cut off times, CMA communication with Licensed Nurse (LN), use of 24 hour report, validation of medications ordered are received, what to do when not received, use of back up pharmacy, and notification of the physician, completed on 07/03/10 by DNS. The Quick Reference Guide (QRG) was laminated and placed in front of each MAR book for "medication not available on 07/01/10. Nurse/CMA orientation will include medication management with the QRG for medication not available guideline. With respect to how the facility will monitor performance to ensure that solutions are sustained: Nursing Management will audit MAR's daily for four weeks for timeliness of medication administration. Nursing Management will review/audit all new admission/readmissions for timely delivery of medications for four weeks. An AD Hoc QA meeting was held on 07/07/10, with the Medical Director via telephone. The results will be submitted to the Performance Improvement (PI)	

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F 333	Continued From page 4 The facility received a faxed copy of the resident's medication orders, prior to Resident #13's arrival. However, the facility awaited an actual copy of the medications and then faxed the orders to the pharmacy. Additionally, the physician came to the facility and wrote a prescription for Hydrocodone (Lortab) 10/325 milligrams (mg) (two tablets) to be administered every four hours. The medication was not delivered as expected that day and there was no medication in the emergency box equivalent to the prescribed dosage. LPN #3 stated Resident #13 was "continually in some degree of pain". An (phone) interview with LPN #2, on 06/30/10 at approximately 3:00 PM, revealed she worked nights and pharmacy orders are usually delivered at approximately 12:00 AM (midnight) daily. She accepted the deliveries and signed the delivery receipt. LPN #2 stated Resident #13's medications, to include the pain medication, (Lortab) were not included in the delivery, the evening of 06/10/10. LPN #2 stated she did not recall any specifics of pain experienced by Resident #13, but was sure he/she experienced pain, due to a diagnoses of "Spinal Collapse". An interview with the Assistant Director of Nursing (ADON), on 07/01/10 at approximately 8:55 AM, revealed she worked the 6:00 PM to 10:00 PM shift, on 06/10/10. The ADON stated she could not recall Resident #13's pain, but remembered introducing herself to the resident and giving the "welcome speech". The ADON stated she was sure the resident's orders were faxed to the Pharmacy, on 06/10/10 at 3:13 PM, because she "looked at the fax log, on 07/01/10". An interview with the Director of Nursing (DON),	F 333	committee for review with recommendations and be monitored for three months through the PI process and ongoing as indicated. Compliance date: 7/22/10	

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F 333	Continued From page 5 on 07/01/10 at approximately 9:00 AM, revealed she did not know when Resident #13 actually received his/her pain medication, but knew there was no medication available for the resident, on 06/10/10. A review of the pharmacy delivery receipt, dated 06/11/10 at 5:43 AM, revealed the delivery of twelve (12) tablets of Hydrocodone 10/325, for Resident #13.	F 333		
F 425 SS=G	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to provide	F 425	F425 The facility will continue to provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement. The facility will provide pharmaceutical services to meet the needs of each resident. The facility will obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. With respect to resident(s) affected by the alleged deficient practice: Resident #13 was discharged home on 06/29/10. Resident #11's physician and responsible party notification of missed dose of hypertensive medication and glaucoma eye drop was completed on 07/01/10 by the DNS with no new orders received. With respect to residents having the potential to be affected by the alleged deficient practice: 07/01/10, a MAR to Medication cart audit was completed to	07/22/10

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F 425	Continued From page 6 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of one resident (#11), in the selected sample of 12, and one resident (#13), not in the selected sample. The facility failed to follow their established policy and procedures to obtain the needed medications in the event the medication was not included in the routine delivery. The facility failed to ensure prescribed medications were availabe for administration for Residents #13 and #11. The facility failed to administer Resident #13's prescribed pain medication on 06/10/10 at 8:00 PM, 06/11/10 at 12:00 AM and at 4:00 AM. Resident #13 described the pain experienced from not having pain medications available during this time period as "worse than excruciating" and "unbearable". Additionally, the facility failed to administer Resident #11's prescribed hypertensive medication at 8:00 PM and prescribed eye drop for the treatment of Glaucoma, on 06/14/10. Findings include: A review of the facility's "Pharmacy Products and Service Agreement", dated 09/13/07 and the facility's policy for "pharmacy telephone numbers/hours and order cut off times", dated 10/15/05, revealed an agreement for the pharmacy to provide "prompt and timely" deliveries to the facility. Deliveries would be made within one hour before and/or after the specified delivery time. In the event the pharmacy failed to make a delivery as required, the facility could obtain delivery of the medication from a third party pharmacy provider or request an emergency delivery of medication. The	F 425	ensure all medications were available in-house by the DNS and Administrator. With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recur: All Licensed Nurses have been re-educated on the facility guideline (Quick Reference Guide; QRG) for medication not available to include ordering of medications at time of admission and new orders, pharmacy cut off times, CMA communication with LN, use of 24 hour report, validation of medications ordered and received, what to do when not received, use of back pharmacy, and notification of the physician, completed on 07/03/10 by DNS. Pharmacy completed re- education on 07/22/10, for LN/CMA's "Back to Basics". The Licensed Nurse receiving the delivered medications from the pharmacy is to validate the medications ordered that day were delivered and administered as ordered or initiates medication not available guideline.	

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F 425	Continued From page 7 pharmacy hours of operation were identified as 8:00 AM until 5:30 PM, with a order cut off at 5:30 PM and 8:00 AM until 3:30 PM on Saturdays, with the cut-off time of 3:30 PM. After hours request for delivery was made through the answering service. In an emergency, nursing staff should check the emergency kit and if the medication was not available, the nurse should communicate with the pharmacy, inform the pharmacy of a STAT situation and a special delivery would be made. A prescriber or nursing staff member could request a special delivery. 1. Resident #13 was admitted to the facility, on 06/10/10 at approximately 4:45 PM, with diagnoses which included Lupus (autoimmune disease), Neutrophilic Eccrine Hydradenitis (skin lesions), Chronic Low Back Pain, Compression Deformity of the Lumbar (L) 3, and Degenerative Joint Disease of the Spine at L4-L5 and L5-Sacrum (S) 1 (low back). Additional diagnoses included Suspect Complex Tear, Degenerative, of Posterior Horn of Medial Meniscus (knee), Hip Tendonitis and Osteoarthritis of Multiple Joints. A review of the Admission Nursing Assessment, dated 06/10/10, revealed the resident expressed he/she was experiencing pain, had a pain history and currently received pain medication. A review of the Medication Administration Record (MAR), dated June 2010, revealed no medications, including pain medications, were administered to Resident #13, on 06/10/10. An interview with Resident #13, on 06/29/10 at approximately 11:15 AM, revealed he/she was admitted to the facility from the hospital, on 06/10/10 in the afternoon. The resident stated	F 425	With respect to how the facility will monitor performance to ensure that solutions are sustained: Validation of reconciliation of medication delivery will be reviewed/audited daily by Administrator/Nursing Management for four weeks. An AD Hoc QA meeting was held 07/01/10 with the Medical Director via telephone. The results will be submitted to the PI committee for review with recommendations and monitored for three months through the PI Process and ongoing as indicated. Completion Date: 7/22/10	

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F 425	Continued From page 8 she was in "terrible pain" and the nurses (unidentified) told him/her the prescribed pain medication would arrive in the next pharmacy delivery, at 8:00 PM. However, the pain medication did not come and she did not receive the medication until the next day. Resident #13 described the pain experienced as "worse than excruciating" and "unbearable". Also, Resident #13 stated that when he/she asked for pain medication, he/she felt he/she "was a pain to them" (referred to staff). A (phone) interview with Resident #13, on 07/01/10 at 1:45 PM, (the resident was discharged on 06/29/10), revealed it was difficult to understand why it took so long to get pain medication, when the pharmacy was located only an hour from the facility. Resident #13 described the pain he/she experienced while without the medication as, "sitting in a bed of hot coals" and stated he/she,"didn't sleep all night, only dozed". An interview with Licensed Practical Nurse (LPN) #3, on 07/01/10 at approximately 9:00 AM, revealed she admitted Resident #13, on 06/10/10. The facility received a faxed copy of the resident's medication orders, prior to Resident #13's arrival. However, the facility awaited an actual copy of the medications and then faxed the orders to the pharmacy. Additionally, the physician came to the facility and wrote a prescription for Hydrocodone (Lortab) 10/325 milligrams (mg) (two tablets) to be administered every four hours. The medication was not delivered as expected that day and there was no medication in the emergency box equivalent to the prescribed dosage. LPN #3 stated Resident #13 was "continually in some degree of pain". LPN #3 stated the facility had experienced problems with late medication deliveries	F 425		

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F 425	Continued From page 9 An (phone) interview with LPN #2, on 06/30/10 at approximately 3:00 PM, revealed she worked nights and pharmacy orders were usually delivered at approximately 12:00 AM (midnight) daily. She accepted the deliveries and signed the delivery receipt. ,LPN #2 stated Resident #13's medications, to include the pain medication, (Lortab) were not included in the delivery, the evening of 06/10/10. LPN #2 stated she did not recall any specifics of pain experienced by Resident #13, but was sure he/she experienced pain, due to a diagnoses of "Spinal Collapse". An interview with the Assistant Director of Nursing (ADON), on 07/01/10 at approximately 8:55 AM, revealed she worked the 6:00 PM to 10:00 PM shift, on 06/10/10. The ADON stated she could not recall Resident #13's pain, but remembered introducing herself to the resident and giving the "welcome speech". The ADON stated she was sure the resident's orders were faxed to the Pharmacy, on 06/10/10 at 3:13 PM, because she "looked at the fax log, on 07/01/10". The ADON stated routine orders faxed to the Pharmacy were expected to arrive by 10:30 PM to 11:00 PM. If a resident required a pain pill the pharmacy was informed that it was needed the same evening. Some medications were available in the emergency back-up, kept by the facility. She stated the Pharmacy was getting medications delivered, but "just not quickly". An interview with the Director of Nursing (DON), on 07/01/10 at approximately 9:00 AM, revealed she did not know when Resident #13 actually received his/her pain medication, but knew there was no medication available for the resident, on 06/10/10 and the medications were delivered on	F 425		

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F 425	Continued From page 10 06/11/10. A review of the pharmacy delivery receipt, dated 06/11/10 at 5:43 AM, revealed the delivery of twelve (12) tablets of Hydrocodone 10/325, for Resident #13. An interview was conducted with the General Manager of the Pharmacy, on 07/01/10 at 9:50 AM and at 10:20 AM, revealed the physician orders for Resident #13 was received by fax at the Pharmacy, at 5:22 PM on 06/10/10. The cut off time for receipt of ordered was 5:30 PM. The General Manager stated he thought whoever received the fax "miss clicked" something on the computer screen and deleted the order. Additionally, a call was received at the pharmacy from the facility, at 11:36 PM on 06/10/10, requesting the medication from the back up pharmacy. However, the back up pharmacy did not receive the notice, until 2:30 AM. The General Manager stated, "for the same reason as before, a miss click". The pharmacy delivered the medication at 5:43 AM, on 06/11/10. 2. Resident #11 was admitted to the facility 06/14/10 with diagnoses to include Congestive Heart Failure, Hypertension, and Glaucoma. A review of Resident #11's admission orders, dated 06/14/10 and printed at 5:51 PM, revealed orders for Hydralazine Hydrochloride (HCL) (treats high blood pressure) 50 milligrams (mg) by mouth three times a day, scheduled to be given at 8:00 AM, 1:00 PM, and 8:00 PM for hypertension. The resident's admission orders also included the medication Lumigan (treats Glaucoma) 0.03% ophthalmic to be administered everyday, at 8:00 PM.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185399	A. BUILDING _____ B. WING _____	07/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 11 A review of Resident 11's Medication Administration Record, for June 2010, revealed the Hydralazine HCL 50 mg nor the Lumigan 0.03% was administered, on 06/14/10 at 8:00 PM. An interview with the Certified Medication Technician (CMT) #1, on 07/01/10 at 1:35 PM, revealed the pharmacy did not deliver the medications on 06/14/10 and therefore, she was unable to administer the medications for Resident 11. CMT #1 stated she informed the charge nurse regarding the unavailability of the medications. CMT #1 also stated the facility had experienced frequent problems due to the pharmacy's failure to ensure delivery of medications was delivered in time, for the 8:00 PM medication pass. An interview with the Licensed Practical Nurse (LPN) #1, on 07/01/10 at 2:05 PM, revealed she faxed Resident 11's medication orders to the pharmacy, on the afternoon of 06/14/10. She indicated on the fax the fact the resident was a new admission and requested the pharmacy send the medications early. LPN #1 stated the pharmacy frequently failed to deliver medications timely, with deliveries from the pharmacy usually occurring between 10:30 PM and midnight. An interview with the General Manager of the pharmacy, on 07/01/10 at 2:30 PM, revealed the pharmacy received the faxed medication orders for Resident #11, at 4:57 PM on 06/14/10. The delivery of the medication was made, at 12:22 AM on 06/15/10. The General Manager stated the pharmacy attempted to work with the facility to ensure medications were delivered to meet the resident's needs. If medications were unavailable to be administered, he believed it would be the	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185399	A. BUILDING _____ B. WING _____	07/01/2010

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F 425	Continued From page 12 responsibility of the licensed nursing staff to determine if the medication was essential and notify the physician or call the pharmacy back.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185399	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 07/07/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at a D.	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Heartland Villa Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and staff interview conducted on 07/07/10, it was determined the facility failed to exercise the generator under load for 30 minutes per month as required by NFPA 99. 3.4.4.1. A review of the emergency generator log on 07/07/10, at 1:30 PM revealed the generator was exercised under load for 15 minutes per month and not 30 minutes per month as required by NFPA. An interview conducted with the Maintenance Director on 07/07/10, at 1:35 PM revealed he did not realize the generator had to be exercised for	K 144	K 144 The facility will continue to test the emergency generator weekly per NFPA 99.3.4.4.1. With respect to resident(s) affected by the alleged deficient practice: No negative outcomes noted. With respect to residents having the potential to be affected by the alleged deficient practice: Maintaince Director ensured the facility monitoring system supported the efficacy of the generator under full load with a 15 minute cool down period.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Paula Thompson Sandra for — Administrator — 7-22-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185399	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/07/2010

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K 144	Continued From page 1 at least 30 minutes per month under load.	K 144	With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recur: 7/7/10, the full load cycle timer was re-adjusted to run 30 minutes in addition to a 15 minute cool down cycle. On 07/7/10 the maintance director was educated on NFPA 99, generator inspection and load testing by Administrator. With respect to how the facility will monitor performance to ensure that solutions are sustained: The Maintenance Director or Environmental Services Director will monitor/record the monthly test. The results will be submitted to the Performance Improvement (PI) committee for review with recommendations and be monitored for three months through the PI process and ongoing as indicated. Compliance Date 7/22/10	7/22/10